DOCUMENT RESUME

ED 396 211 CG 027 127

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TITLE Increasing the Effectiveness of De-escalation of Aggressive Behaviors in the Young Child.
PUB DATE 95
NOTE 109p.; Master's Practicum, Nova Southeastern University.
PUB TYPE Dissertations/Theses - Practicum Papers (043) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC05 Plus Postage.
DESCRIPTORS *Aggression; Antisocial Behavior; Behavioral Objectives; *Behavior Change; Behavior Disorders; Child Behavior; Child Psychology; Children; Clinical Experience; Elementary Education; *Inservice Education; Intervention; *Job Training; *Mental Health Clinics; Problem Children; *Young Children

ABSTRACT

Due to the overuse of physical containment within the agency where this practicum study was conducted, an in-service training program was designed and implemented aimed at better preparing staff to de-escalate aggressive behavior. A three hour training session and a conclusive one-and-a-half hour long testing period (involving lecture, role play, video taped situations, and group discussion) were implemented. Staff trainees were observed within this milieu in order to insure that a transfer of learning to the practicum setting had been accomplished. The training increased staff verbal de-escalation skills, behavioral observation skills, and decreased assaultive behavior by eight 6- to 12-year-old girls in a residential treatment facility. Eight appendices include an implementation plan, list of physical restraints, injury log, de-escalation training guide, and a documentation review form. (Contains 17 references.) (Author/TS)

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ED 396 211

Increasing the Effectiveness of De escalation of Aggressive Behaviors in the Young Child

by

Alison Mueller

Cohort 68

A Practicum Report to the Master's Program
in Child Care, Youth Care, and Family Support
in Partial Fulfillment of the Requirements for the
Degree of Master of Science

NOVA SOUTHEASTERN UNIVERSITY

1995

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11/18/95
Date

Alison Mueller
Signature of Student

Abstract

Increasing the effectiveness of de escalation of aggressive behaviors in the young child. Mueller, Alison L.,1995: Practicum Report, Nova Southeastern University, Master's Program for Child Care, Youth Care, and Family Support. Descriptors: Verbal De Escalation/Verbal Intervention/Behavior Management/Intervention Strategies/Managing Aggressive Behavior/Preventive Strategies.

Due to the overuse of physical containment within the practicum agency, the author designed and implemented an in - service training to better prepare staff to de escalate aggressive behavior. A three hour training and a conclusive hour and thirty minute testing period was implemented which encompassed lecture, role play, video taped situations and group discussion. The trainees were observed within the milieu to insure a transfer of learning to the practicum setting had been accomplished.

The training increased staff verbal de escalation skills, behavioral observation skills, and decreased assaultive behavior by residents. Appendices include an implementation plan, list of physical restraints, injury log, de escalation training guide, and a documentation review form.

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Chapter 1

Introduction and Background

The practicum agency has been in existence for over 100 years. The original plant design resembled a typical late 19th, early 20th century orphanage setting. Within the past few years the facility has been renovated to reflect the goals of a modern, ever evolving residential youth care agency. In 1991, the agency received accreditation, and as of October, 1995 has been upgraded to a formal designation as a residential treatment facility.

With this in mind the practicum student will give a brief look at the agency as it exists today. This not-for-profit agency is located in a large urban setting. Within their residential program, service is provided for up to 71 male and female residents, age 6 through 17. Ten separate housing units, contained in one large building complex, house 7 to 8 residents each.

The agency provides what they refer to as a 'circle of care'. Programs which are part of this 'circle of care' include: foster care, residential care, and the independent living arrangement (provided for residents transitioning to independence).

Aside from the 10 houses, the agency has an additional house which contains 4 bedrooms. This house is available for multiple uses. It has been used to house residents for pre-independence, and it has also served as a special unit for youth in crisis.

The Setting in Which the Problem Occurs

I had selected the youngest girl's unit for the focus of my practicum. There are 8 girls on this unit, ranging in age from 6 to 12 years. Seven of the eight girls are African-American, and the unit on average, is 85% to 100% African-American. The girls were placed in this program by the Department of Children and Family Services (DCFS) due, mainly to abuse and/or neglect.

There are four bedrooms on the unit. Each girl shares a bedroom with a roommate. There is also a common living room, a dining area (although meals are served in the cafeteria), a bathroom with a shower unit, and a separate tub. Two toilet stalls are also provided. A staff office is located on the unit; this office has been placed in an area which allows for visibility of all the bedrooms.

All of the girls attend group therapy, individual therapy, and therapeutic recreation. Each girl is provided on-going case work services, medical services, opportunities for religious practice, and education appropriate to her individual needs.

This was a new unit for this agency. In the past, there was only one girl's unit which served all of the residential female population, age 6 through 17. The agency began this unit in May of 1994, based on a generalist model. The unit was self-contained, and all the staff hired were required to have a Bachelor's degree. The agency has since moved away from the generalist model. The staff women from this unit, are fairly

young and inexperienced. The staffing pattern is as follows - on an overnight shift, there is only one staff working. This staff person overlaps with the day staff person for two hours, when, together, they assist the girls in preparing for the day - hygiene routine, breakfast, and preparation for school. During the prime shift of 1pm to 11pm, there are two to three staff working. These women work on a scheduled 4 day work week with 10 hour shifts. Of the seven women working on this unit, only two are African-American, one is Hispanic, and the remaining four are Caucasian.

The use of male staff on female units is not part of the agency hiring practice, but the agency has, on occasion, utilized a long time African-American male employee from another unit. This male had been effective with the young girl residents, although some staff have reservations about utilizing male staff on this unit.

The crisis intervention techniques used on this unit, and in the agency as a whole were **PART** (Professional Assault Response Training), and

for severe, and frequent, behavior problems, individual treatment strategies were developed. Within these strategies, the problem was identified, past interventions, and results of same were summarized, and a treatment strategy with time frames and measurable outcomes was developed.

Behaviors which commonly warranted an intervention were attempts to physically harm staff, peers, or self, and major property damage. Examples of typical behaviors of girls needing crisis intervention were - kicking, biting, punching, hair-pulling, spitting, and throwing objects.

Student's Role in the Setting

The practicum student has been with this agency for the past 13 years. Prior to the student's present position, the student had been the coordinator of the Therapeutic Recreation Program for the agency, and supervised a staff of 3.

Before the practicum student came to that program, the form of recreation that was provided was at the level of *roll out a ball to the residents, and supervise them to make sure that there were no injuries.* The student developed the therapeutic recreation program, set up documentation, implemented the program, and hired the necessary staff to run same. The therapeutic recreation department provides: treatment, leisure education, and recreation participation.

As of November of 1995, the practicum student has been in the position of director of specialized services for 15 months. The student supervises 3 residential unit coordinators, and the therapeutic recreation department. The student is responsible for the agency's older girl's unit, the sexually aggressive children's unit, and the younger girl's unit (which was the focus of this practicum). The student shares the responsibility for training child care workers with the director of the residential program. Together, we plan the on-going weekly trainings for all agency child care

workers.

Prior to the practicum student's latest position, the student had presented trainings for child care staff within the focus agency, as well as child care workers at various conferences. Some topics of trainings which the student had presented were: stress management, use of activities to reach treatment goals, anger management, and Oklahoma training (40 hour advanced child care training).

As director of specialized services, within the framework of the focus agency, the practicum student was provided with a great deal of autonomy, and ample access to any necessary resources. As both the supervisor of the younger girl's unit coordinator, and one of the primary trainers for the agency program, the student was in an excellent position to implement a program which addressed the ability of staff, on the younger girl's unit, to address the behavior of the aggressive child.

Chapter II

The Problem

Problem Statement

The practicum agency's level of addressing the behavior of the younger aggressive child was inadequate. Better preparation of direct service child and youth care workers was necessary, in order, to effectively manage the aggressive child being referred to the agency at an increasing rate.

Documentation of the Problem

Residents routinely assaulted staff: kicking, scratching, biting and punching. The level of injury to staff was at the point where staff had needed to be sent home, or sent to a doctor for medical attention. Staff had been punched in the face, bitten, and scratched to the point of breaking the skin.

Within PART training, the section on the developmental model

addressed those behaviors. "From the perspective of human development, violence is a function of age. Younger people are more likely to be violent than older people, and they can be expected to be violent more frequently" (Smith, (PART) 1983, pp. 7 & 8).

PART also provides a section which describes normal development in the ability to inhibit violent outbursts. "Pre-school children - typically have little ability to control their explosive outbursts. They are easily provoked into hitting, kicking, scratching, and biting over relatively simple issues related to such things as toys, candy and territory" (Smith, (PART) 1983, p. 8). The section goes on to state, the early elementary child is provoked into assault over issues of pride and territory.

A solid understanding of tnese concepts would better prepare staff to recognize, and address, these situations before they escalated into physical assault.

Aside from the issue of injuries sustained by staff, there was also

an increase in the need for physical interventions by two of the younger girls in particular. The current behavior system at the agency, and intervention strategies, had made no significant change in the frequency, and extreme nature of aggressive behavior with these two residents. These two girls represented the type of client the agency expected to service more often in the near future.

The agency had received accreditation as a residential treatment facility. According to Daniel L. Davis, PhD, and Lucinda H. Boster, MA, in their article - 'Cognitive-Behavioral-Expressive Interventions with Aggressive and Resistant Youth', "Increasingly, youth placed in residential treatment facilities demonstrate violent, aggressive behavior." "Trends in provision of services to youth reflect current emphasis upon maintaining youth at home and minimizing out of home care placement. Accordingly, youth placed in residential settings will be those who present behaviors, most likely violence and assaultiveness, who cannot be

successfully treated in the community setting" (1993, p. 55).

The agency's level of treating the aggressive child was not sufficient for the type of youth who will be referred to the residential program. The agency had to find a better way to prepare child care staff for the aggressive child.

In order to document the extent of the problem of aggressive behavior within the practicum setting, the practicum student collected a summary of all physical restraints which were performed between January 1, 1995, and April 10, 1995. Of the eight girls on this dorm, one resident had never received any type of physical intervention during that time period, two residents were physically restrained twice, one resident had six physical interventions, and two other residents invoked seven physical interventions. The incidents of physical intervention for the two remaining girls on this unit were dramatic. Resident A (a seven year old African-American girl) needed to be restrained twenty-four times during

that time period. Resident B (a ten year old African-American girl) required physical restraint twenty-two times over that same period. (see Appendix B)

Since the beginning of April, 1995, Residents A and B are the only ones who have needed to be physically restrained. In addition, looking at the physical intervention listing (Appendix B), Residents A and B needed to be restrained a second time, on the same day, on 5 separate occasions.

As stated earlier, these two girls reflected the type of clients for which the agency was expecting to receive more referrals. A typical incident would be that one of these residents would tease another girl, or call her a name which upset the other resident, who responded with a physical assault. At that point, a staff person was forced to intercede. Once the staff person attempted to remove the resident initiating the conflict from the incident, the child became assaultive towards the staff person -

punching and scratching. When this occurred, per agency policy, staff proceeded to implement either a one person containment (baskethold), or if two staff were available, a two person containment was initiated.

For the two most problematic residents a variety of treatment strategies had been utilized. One strategy was the use of a crisis room when the residents reached the point where normally staff would be forced into a physical restraint. This strategy had some merits, however it was more reactionary, and not preventative in nature. Another strategy which had resulted in very limited, and short term, success had been the use of contracts specifying the time of the day residents could use to deal with their anger under specific terms. Staff had also tried to ignore minor negative behavior, trying to extinguish it by not providing reinforcement. This had caused the behavior to escalate, and staff were then forced to address those behaviors.

Overall, past interventions had been ineffective at reducing

aggression, and the need for physical intervention (either restraint, or physical escort).

To further document the problem note the occupational injury / illness report log (Appendix C). In the span of just over one month, March 10, 1995 through April 12, 1995, of the six staff sent to the doctor for injuries sustained on the job, five of the staff, as indicated by the # on the log, came from the little girls' dorm. The staff were injured by bites, scratches, kicks, and punches. Of all the forms of physical aggression, bites were the most common form of attack, and the one reported most frustrating by staff.

Those injuries were sustained during the implementation of physical restraint. Physical restraint, as it is taught in PART, should be used as a last resort, but appeared to be used very frequently on this dorm.

The practicum student surveyed staff trainers from three other agencies, within the geographical area of the practicum agency. All three

agencies used different crisis intervention techniques. One agency used Crisis Prevention Intervention with their younger boys' facility, while using Professional Assault Response Training (PART) for their older boys' facility. Another agency used Therapeutic Crisis Intervention. The third agency used an intervention training developed by their own staff.

All three programs had basic training, but found themselves adding on more supplemental training, i.e. role playing typical incidents which had ended in physical restraints, understanding Attention Deficit Disorder, and Anger Management. Although there seemed to be little consensus about which was the best crisis intervention training, and what training was needed by all staff to deal with the aggressive child; all trainers agreed more emphasis needed to be placed on teaching staff how to effectively intervene verbally when a situation began to escalate. Trainers also agreed that it was important to find a crisis intervention component within their program which worked at their agency, with their residents.

Analysis of the Problem

1) At the pracitcum site, there was no pre-service training, and new staff were unprepared to effectively de escalate a crisis situation.

In her article titled 'A Conceptual Overview: Issues in Responding to Physical Assaultiveness', Karen Vander Ven noted, "The importance of experience in child care worker handling of acting out is underscored by Orlowski (1984), whose research findings indicate that *inexperienced* child care workers in situations involving assaultive behavior both perceive greater physical threat to themselves and employ more physical activity in their interventions than those with more experience" (1988, p. 10). Orlowski goes on to state there is a need for orientation of new workers.

Within the practicum site, new workers received training sometime during their first 60 days, but this often came after they nad been faced with a crisis situation for which they were unprepared to address.

2) In the practicum site training schedule, crisis intervention training was provided annually. The practicum student had spoken with one of the trainers who stated that staff should attend a crisis intervention training three to four times annually, in order to be prepared to effectively use the training. Further, the problem was that as long as a staff person attended the training and fully participated, the staff was considered properly trained, even though there was no assessment given to verify the acquisition of the skills and the concepts taught.

The training provided at the practicum site was inadequate in preparing staff to work with the aggressive child. There was also a need to assess staff's ability to correctly use the skills taught within the training.

3) One of the agencies the practicum student contacted, by phone, stated that one of the factors which contributed to staff's inability to adequately address aggressive behaviors was staff turnover.

Turnover had been a problem within the focus unit of my proposed

practicum project. Two new employees had joined this unit and negative behaviors, which had begun to decline, had re surfaced.

4) Author's Davis and Boster noted in their previously referenced article (p. 16 of this report) that "Research on national, regional and local levels consistently demonstrate that youth referred for residential placement evidence violent and aggressive ideation and behavior. Residential treatment centers, therefore must develop treatment strategies to address the needs of these youth" (1993, p. 55).

This referral of the more aggressive youth to residential treatment necessitates more effective staff preparation.

Chapter III

Goals and Objectives

Within the population of the practicum focus, there were several residents who displayed extreme, and frequent, aggressive behaviors which staff were unable to effectively address. The present behavior system, and intervention strategies, had made no significant impact in de escalating these behaviors. The following goal and five objectives were proposed to implement a change strategy designed to help ameliorate this problem.

Goal: Child and Youth Care staff will more frequently, and more effectively, use non - physical de escalation techniques in managing aggressive behavior.

Objective 1: By week 4 of the implementation period, the practicum student will develop a program-specific training curriculum in non - physical crisis de escalation techniques. The measure of the objective completion will be the written curriculum, which will be attached to the

practicum report. (Appendix D)

Objective 2: By week 6 of the implementation period, the practicum student, along with other agency trainers, will instruct 100% of the program's child and youth care staff in non - physical crisis de escalation techniques. Objective completion will be verified through an attendance form, which will be attached to the practicum report. (Appendix E)

Objective 3: On completion of the training, 100% of the trainees will demonstrate at least 80% comprehension of the curriculum content, as measured by an objective, 20 item written post-test, which will be attached to the practicum report. (Appendix F)

Objective 4: On completion of the training, 100% of the trainees will demonstrate proficiency in applying de escalation techniques in a role-play situation. A panel made up of trainers will judge trainees as proficient when they have demonstrated 80% of the required skills, as listed on a checklist, which will be attached to the practicum report.

(Appendix G)

Objective 5: On completion of training and testing, child and youth care staff will demonstrate the transfer of de escalation skills to at least 75% of work situations in which these skills may appropriately apply. Completion of this objective will be measured through routine incident documentation, and the focus unit running log, as well as supervisory feedback forms, reviewed by the trainers.

Chapter IV

Solution Strategy

Review of Existing Programs, Models, and Approaches

There are a number of staff training curricula / methodologies available to prepare direct service child care workers to address the behavior of the aggressive child. Emphasis on de escalation within intervention techniques was of particular interest to me for my practicum focus. Experts had pointed out the critical importance of the role of staff in either escalating or de escalating the 'conflict cycle'. Author's Wood and Long stated,"One way of looking at a crisis is to see it as a product of a student's stress, kept alive by the reactions of others. When a student's feelings are aroused by stress, the student will behave in ways that buffer against painful feelings. This behavior usually is viewed as negative by others (adults and peers), causing them to react negatively to the student. This reaction from others causes additional stress for the student. We

call this the conflict cycle" (1991, p. 33).

Long further pointed out, that within the cycle there were points where an appropriate verbal intervention could help de escalate the cycle. Training which addressed how to break the cycle of conflict allowed staff the opportunity to verbally de escalate a situation before there was a need to intervene physically.

Ernst Federn further supports that contention. In his text titled 'The Therapeutic Management of Violence', Federn states, "There are many ways to avoid violence. The thing to do is to talk and try not to use any bodily restraint" (1989, p.5).

Not enough emphasis can be placed on how the actions of a staff person addressing a child's behavior can either escalate or de escalate the situation. Bernice Weissbourd, who in 1984 was the president of Family Focus (an agency in the Chicago area that provides drop-in centers for parents of children three years old and under) stated, "If a

child is angry, kicking or biting and seemingly uncontrollable, your strong and firm presence is definitely required to restrain him, to prevent him from continuing the attack, and to aid him in regaining control of himself." "You are there to be supportive and to help him redirect his energies. Getting angry and punishing him for being angry is counterproductive and may only set the pattern for more and more angry behavior" (Parents, November, 1984. p. 168).

The practicum student's goal was for child care personnel to more frequently, and effectively use non-physical de escalation techniques in managing aggressive behaviors. To insure this was done on a consistent basis, all child care staff must receive the same training in de escalation techniques.

In their paper, Aggression Treatment Project, the authors M. Forster and K. McCarthy noted, "Intensive training--in all aspects of the powerful environment, and not merely in 'crisis intervention' -- early on in the

worker's career, and continuous training thereafter, is vital both to maximizing the program's treatment effectiveness and to minimizing the risk associated with this selfsame treatment" (1994 , p. 32).

In the Management of Aggressive Behavior, author Ouellette declared, "Non-verbal and verbal signals are the most widely used forms of communication. Yet, these are the most neglected areas of training. Human service personnel are frequently placed in danger of assault because they are unaware of the 'non-verbal' and 'verbal' signals given by aggressors. Research has shown that non-verbal and verbal skills are necessary to prevent most encounters where force is used" (1993, p.2). This point was further emphasized in the article - Days of Rage - Special report on the Los Angeles Riots after the Rodney King Verdict, "Some experts think physical presence and communication skills alone could handle up to 98% of the incidents potentially requiring force" (News and World Report, May 11, 1992, 20.).

The practicum student had reviewed three crisis intervention training programs, each had its merits, and all have many similarities. I concentrated on the pre-restraint, preventative techniques within each program. The first was PART (Professional Assault Response Training); this training was very academic, discussing models for understanding assaultive/aggressive behavior. This intervention program, in my opinion, was too didactic, giving more generalities for recognition of types of behavior, reasons behind the behavior and risk management, but less specifics involving actual verbal techniques to implement. PART was the only one of the three without an accompanying video which demonstrated the techniques. Although a version of PART was what the practicum agency used, supervisors were dissatisfied with the level of preparation of the staff.

The second crisis intervention training program this student reviewed was CPI (Crisis Prevention Intervention). CPI had more general

techniques, and less specifically applicable interventions. A great deal of the training was along the lines of what you should not do, instead of what is proscribed to do. I finished the preventative techniques portion of CPI feeling unprepared to de escalate any situation. In this student's opinion, there was not enough material given on prevention and de escalation.

The third crisis intervention training this student examined was TCI (Therapeutic Crisis Intervention). TCI drew many of the verbal and non-verbal de escalation techniques from the work of Fritz Redl and David Wineman. Planned ignoring, proximity and touch, hypodermic affection, and hurdle help, are techniques found in Fritz Redl and David Wineman's," Controls from Within Techniques for the Treatment of the Aggressive Child", and used in TCI preventive techniques. In my opinion TCI had practical, usable techniques. There was a great deal of emphasis on the use of the Life Space Interview, and Conflict Resolution. Of the three techniques, this practicum student had reviewed, TCI gave the most specific training on verbal, and non-verbal communication in a

very progressive manner, from the least intrusive to the most intrusive interventions.

In Karen Vander Ven's article 'A Conceptual Overview: Issues in Responding to Physical Assaultiveness', she lent support to the idea of sequential intervention. "It refers to the strategy of handling situations with an intervention equal to the response demand contained in such situations, but not bringing more counterforce to bear than is necessary unless the intervention does not succeed, at which point a successively more powerful one should be evoked" (1988, p. 6).

In addition, this student reviewed intensive teaching, which was a method used by another agency. That agency used a Family Living Teacher Model. Many of the techniques were specific to that type of model, while other techniques were versions of interventions found in TCI, and PART. A few of the interventions would be counter-indicated by the practicum agency's working model of behavior modification.

Lastly, I looked at Roland Ouellette's book, " Management of

Aggressive Behavior". In his book, non-verbal and verbal communication skills were broken down into specific sections. Everything you needed to observe, and the details of situations, were spelled out in very precise terms. The author addressed space, eye contact, gestures and postures, active listening, stages of conflict and submission as distinct topics. "Management of Aggressive Behavior" could be taught in its entirety or used as supplemental material for any other program which was chosen.

Solution Strategy Implemented

After reviewing the available literature, this student proposed to combine TCI with the techniques taught in 'Management of Aggressive Behavior', and developed my own training curriculum to better prepare practicum agency staff to effectively de escalate aggressive behavior.

I had chosen to develop my own training curriculum because I felt that each reviewed curriculum was lacking.

From reviewing training approaches, this student felt not enough time and emphasis was placed on the assessment of non verbal cues before beginning an intervention. The need to adequately assess non verbal cues seemed especially important in addressing the younger child who is less able to verbalize their feelings.

With Ouellette's breakdown of visual cues, and TCI's management techniques grounded in the works of Redl and Wineman, a training involving the use of both sources seemed to provide the most comprehensive training.

All parties involved in this project were either staff this student was responsible for in a supervisory capacity, or peers I worked with on a daily basis. To insure that there was 100% attendance by the focus unit staff, the training was mandatory and scheduled well in advance to provide an opportunity to make any adjustments which may have been necessary. The training was scheduled on two different days so staff had the

option of which day they would attend. Additional time was made available for staff who were unable to meet the objectives, and individual instruction was provided.

The two agency trainers identified to assist with the training, and skill evaluation were the director of the residential program, and the assistant coordinator for the junior girls' dorm, who was already a trainer in PART crisis intervention.

This student proposed to develop the training curriculum and allow the two trainers, who assisted me in the training, to review the curriculum and provide feedback. After all revisions, the curriculum was taught to all staff on the focus unit.

During the development of the curriculum, the post-test was developed, and then reviewed by my co-trainers, and revisions were made at that time.

Role plays were developed, from reviewing past physical restraint

and discipline reports, to identify typical problem situations. Trainers met to develop a checklist to measure proficiency in the skill demonstration.

Lastly, the staff and unit supervisor, were taught how to write up the de escalation techniques in incident reports, as well as the running log. The unit supervisor, and her assistant, were taught the skills to observe, and record, on observational feedback forms.

The authorization to carry out this training had been granted by the vice-president of the residential program who supervised all aspects of the personnel and materials involved in this project.

Chapter V

Strategies Employed: Action Taken and Results

Activities Implemented

Although actual time necessary for each activity varied somewhat, the scheduled activities were implemented as planned. The project began with a meeting with the focus unit coordinator to discuss the purpose of training and training dates. Using Therapeutic Crisis Intervention and Management of Aggressive Behavior the curriculum was developed and then reviewed by my co - trainers.

One addition to the activities was my decision not only to develop role plays, but video tape residents in common situations which often escalate if not addressed appropriately. The video included 4 different scenarios which lasted about 30 seconds in length and allowed for group discussion of possible intervention techniques. I chose situations which I had found led to the need for physical interventions in the past. Through group

discussion of a variety of intervention techniques, the trainees were able to identify the advantages and disadvantages of their intervention strategies. Trainees reported that the visual representation of the situations discussed reinforced their ability to transfer techniques into practice

By the second week, I reviewed physical restraint forms, discipline reports, individual daily logs and the unit running log. One thing which was noticeably absent in the documentation were precursors to the full blown crisis. The staff began documenting somewhere during the escalation, and they were failing to document the triggering event. Thomas N. Fairchild notes, in his capacity of editor of 'Crisis Intervention Strategies for School - Based Helpers', "...the notion that some crises might also be anticipated and prepared for suggested many possibilities for preventative mental health efforts" (1986, p. 6).

The documentation was often too vague, and staff did not identify

specific behaviors i.e. throwing items, but rather stated 'lost control' or 'went off'. Staff also ceased documentation at the point where the child regained control. The follow up, or processing, was not documented. The documentation reviews of the first few weeks confirmed the necessity for the de escalation training.

During the next step, I met with the unit coordinator and discussed the need to review staff documentation with the staff giving feedback for improved performance. I developed a *Documentation Review Form* (See Appendix H) for the team to use to review physical intervention, discipline reports and unusual incident reports.

Within the team meeting, we initiated the use of the *documentation review form*, focusing only on incidents of physical intervention. For each incident, the team came up with two recommendations for use with each resident in the future. Recommendations ranged from removing the resident from a situation before it has an opportunity to escalate, to

providing more one on one staff supervision or attention.

By week 6 the training was implemented; 3 hours were spent on the training itself, while an additional 1 & 1/2 hours were needed to assess each individual participant's ability to utilize the de escalation techniques. On the post test, scores ranged from 75% to 100%. Of the seven participants only one had failed to score the required passing grade of 80%.

I reviewed the training material with the woman who failed and she then re tested, passing with a grade of 80%. With each trainee, I reviewed the feedback given by all trainers regarding their role plays.

Author Naomi Golan identifies a lack of crisis intervention training within the schools of social work as being problematic for students preparing for social work positions. In the author's text titled 'Treatment in Crisis Situations' she states, "When this was discussed [crisis intervention training] with methods instructors, many replied that crisis intervention was usually left to be covered in field instruction by supervisors, more or

less on an ad hoc basis, when a crisis would crop up in an ongoing case." The author goes on to state that "Much of current practice appears to have been learned informally through practice wisdom gleaned over the years, the interchange of ideas, observations, and experiences among staff members, and independent examination of the professional literature. Only recently have practice manuals devoted to this area begun to appear" (1978, pp. 227 & 228).

Ms. Golan's observations appeared to support my position that there was a need to focus heavily on this type of in-service training.

For the next three weeks, we reviewed documentation and observed staff on their unit interacting with the residents. Gradually, with the ongoing feedback about the logs and the documentation being too broad and vague i.e. 'good day', staff began to use more behaviorally specific terms to describe all aspects of the residents' daily living.

During the last week (week 10), I met with staff individually to discern what they felt had been most beneficial, and what they had been able to

implement into their work with the residents. A summary of staff feedback follows. Although most of the women stated they were uncomfortable with role plays, they further stated the role plays were most applicable to their work. With more practice, most felt they could probably become more comfortable with this form of training.

Overall, the trainees stated they are more cognizant of behavior patterns of individual residents, and find themselves interceding early during the escalation phase, or even anticipating the triggering event i.e. *mom fails to come for a visit*. At least half of the participants identified and shared alternative interventions to reach the same end, this being very helpful in expanding their own repertoire of intervention techniques. In particular, the staff felt receiving the training as a group was beneficial to their dorm team.

Results

The individual objectives support that the goal of more frequent and effective use of non-physical de escalation techniques are being

utilized in managing aggressive behavior.

"Special training for crisis intervention is a pivotal question which often determines the extent to which it becomes part of a worker's practice armamentarium" (Golan, p. 227). Now that de escalation training has been initiated, continuous retraining will become important to maintain the skills which have been developed. Although the terminology may be different, author A. Lee Parks in his article Managing Violent and Disruptive Students in 'Crisis Intervention Strategies for School - Based Helpers' identifies components of prevention and intervention which are similar to those listed in this student's teaching guide. Parks speaks of re structuring the environment, planned ignoring, proximity control, signal interference, interest boosting and routine (1986, pp. 286 -317).

The *Teaching Guide* (see Appendix D) demonstrated that the first objective had been met. The curriculum for de escalation of aggressive behavior addressed the areas of awareness of children's needs and

behaviors, identified causes of violent behavior, identified non - verbal signals which allow for early recognition of escalation, provided behavior management techniques, stages of crisis, intervention approaches and the life space interview. A key aspect of the life space interview is exploring the child's perception. Steven Shiendling in his article -' The Therapeutic Diamond:' states "What is critical for staff to understand is that the 'experience' for emotionally disturbed children in residential treatment is usually quite different for the child than it appears to be for the staff. What the staff sees and believes may be quite different than the child's experience." He goes on to note that staff "at the very least must understand the view of the child" (1995, p. 48).

The second objective stated that 100% of the child and youth care staff in the focus unit would be instructed using the de escalation techniques. The *attendance sheet* (see Appendix E) confirmed that all 7 women attended the training.

The third objective that 100% of the trainees would achieve at least

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80% on a 20 question written post-test which measured comprehension of the curriculum content.

The results:

M.B.	100%		
N.T.	95%		
J.G.	100%		
D.W.	100%		
H.V.	95%		
J.W.	95%		
A.A.	75%	/	80% on re-test

Overall, test results far exceeded minimal expectations set for successful completion of the training.

On the role plays, all women successfully demonstrated an adequate level of proficiency in de escalating a situation using the required skills as listed in Appendix G (Role Play Checklist).

We found objective five difficult to measure. It stated that staff would use de escalation skills in at least 75% of work situations in which those skills may appropriately apply. We have noted a significant decrease in the need for physical restraint on this unit.

From the period after the training, 8/9/95 until 9/7/95, only two physical restraints had been administered on girls from the focus unit by any of the trainees. This total represents a decrease of 80% in comparison with the number of restraints during the pre-training period.

During observation times, staff have consistently used various de escalation techniques while interceding in incidents. We found it hard to measure in a quantitative manner how often these skills are used to de escalate situations since staff incorporated the skills into all their daily interactions with the residents. Through the use of the running log, staff significantly focused on and improved the quality and quantity of their documentation. Where in the past, one paragraph summarized a shift - now staff minimally write a page in summary of their shift. Within the log, staff are more behaviorally specific regarding their observations and interventions.

A significant change in logging is the notation of behavior patterns

which are observed. An example would be, 'Resident A woke up in an angry mood and started arguing with peers, the afternoon staff may need to keep a close eye on her because this usually leads to a poor school day'. Staff communication and consistency have improved, and situations are anticipated and addressed generally before they have an opportunity to escalate. Author Parks notes that "Prevention should always be preferred to confrontation" (1986, p. 288).

The literature supports the need for in-service training in general. In his book 'Developmental Group Care of Children and Youth', author Maier states "Training has to focus on what skills and knowledge components care workers need to acquire rather than what kind of personal traits they must exhibit (1987, p. 196).

Pertaining to de escalation in particular, "staff at all levels must take part in realistic training about both verbal de-escalation methods and effective techniques to counter physical aggression." Van Rybroek, et al..

Psychiatric Services, Safer Psychiatric Facilities. The writers note that "When institutions are unsafe because the staff are not sufficiently trained to deal effectively with aggression, it is naive to believe the conditions foster good treatment" (May 1995, p. 516).

The skills taught in the de escalation training are further supported by Nancy Cotton in 'Lessons from the Lion's Den'. Author Cotton emphasizes the value of verbal communication: reflective listening and feeling statements, as well as non verbal: eye contact, facial expressions, proximity and attentiveness. (1993, pp. 87 -129)

The need for developing this sort of training is only highlighted by author Golan's view of the lack of text in this area (p. 43 of this report), and the following statement by Van Rybroek et al., "Although Periodic articles about inpatient aggression are published, there is a dearth of specific information and discussion about training staff in the practical and effective verbal skills and physical alternatives needed for controlling aggressive patients" (p. 516). Golan's statement was published in 1978,

Van Rybroek's similar concerns are noted in 1995.

In conclusion, while none of the girls have left the agency since the initiation of this practicum and restraints have significantly decreased, this student attributes much of the change to the improved level of de escalation skills.

Chapter VI

Conclusions and Recommendations

In past trainings at the focus agency, when de escalation was only taught as a small component of our crisis intervention training, staff walked away ready to restrain. The seven women from the focus unit of the de escalation training left the training with a conviction that they would be trying to prevent the need for physical restraint. With the emphasis placed on prevention and de escalation techniques, staff are more focused on preventing a crisis situation rather than reacting to one.

To this end, trainers have seen a significant change in the staff logs. More documentation is given to events observed prior to the crisis phase when an incident does occur. Our rate of physical restraints by the trainees has decreased up to 80% on the monthly report. Although, this student cannot attribute the decline in restraints solely to the training, there appears to be a correlation between the de escalation training and a

reduction in physical restraints used as interventions. From the period of 1/1/95 through 4/10/95, the two most problematic residents, on the focus unit, were restrained a total of forty-six times (averaging about ten restraints per month). During the post-training assessment time of 8/9/95 through 9/7/95, there were a total of two restraints performed with these residents by the child care workers of the focus unit. The number of restraints decreased 80% from the pre-training totals.

On the post-test of the trainees, the trainees scored well in both increased knowledge of de escalation, and an increase in skill acquisition. The 7 trainees scored an 80% or better on the written post - training examination of knowledge of de escalation techniques. Further, all 7 women were able to successfully complete a skill demonstration utilizing the skills within a role play situation.

The original physical intervention training by its very title, PART (Professional Assault Response Training), prepared staff to address

situations once they reached the crisis phase. Through the use of semi - annual de escalation training, the practicum agency would prepare staff to de escalate situations before they climaxed to a point of assault.

As was indicated in chapter V, there is a dearth of training in de escalation techniques with the aggressive child, but the aggressive child is increasingly becoming the norm in residential treatment facilities.

In my initial survey of other agencies, the problem of emphasis on physical restraint training, and a lack of equal emphasis on the importance of de escalation, supports the need for many agencies, in my immediate service provider area, to receive this type of training.

In particular the use of role plays, and scenarios of actual past incidents, reinforces the practice and practical application of the skills. As Steve Young noted in the 1978 issue of *Child Care Work in Focus* pertaining to Therapeutic Crisis Intervention, "Roleplaying provides a great way to practice skills and yet not have to take the risk of having

them backfire with 'real children'. It also provides an opportunity for receiving feedback, ... (reprinted @ Residential Child Care Project, p. 635).

Within the practicum agency the need for increased emphasis on this type of training has become evident for two particular reasons. First, in preparation for managed care the practicum agency has already been asked to step down to foster care many residents who have few behavior problems, and are not in need of the intense therapeutic environment of a residential facility. Secondly, within the past month (October, 1995), the practicum agency has been upgraded from a residential facility to an accreditation of a residential treatment facility, and can well expect to receive referrals for placement of youth who would have been turned away because of extreme behavior problems in the past.

In chapter V, I have demonstrated the support for training in general, and de escalation training in particular within the literature. I am in total

agreement with Van Rybroek and others who believe if we can not effectively deal with aggression we can not believe we foster good treatment.

De escalation is a key area of training for anyone working with aggressive youth. Therefore, in conclusion, it stands to reason that more effective training leads to a better treatment environment.

Recommendations

Within the practicum agency, trainers have begun to use the de escalation training as one day of the five day pre-service training. We administered the post-test both in pre and post- training, a summation of the results follow. On the twenty question pre-test the trainees answered incorrectly at least six, and up to ten, of the questions. While on the post-test none of the 8 Trainees answered more than two of those twenty questions incorrectly.

For new staff, the role plays, followed by feedback and discussion,

were an invaluable training tool. The focus agency has decided to keep the de escalation training as a component of the pre-service training.

The practicum agency has further decided to train each unit in de escalation techniques. Training each unit team together will provide a greater potential that the techniques will be utilized on each unit.

The literature further supports periodic retraining and the practicum agency plans to retrain on de escalation minimally semi-annually, if not quarterly. In addition, if a unit has a serious increase in physical restraints, that unit may be referred for retraining.

At present, the practicum agency shares a training pool for advanced child care training, and several agencies have expressed an interest in broadening these shared resources. With one agency, the practicum agency may merge crisis intervention training, and that agency may be interested in the de escalation training for their staff as well.

The focus of the de escalation training was a girls' unit ages six through twelve; however, the practicum agency feels this training

would apply to all of their residential units, which encompass males and females ages five through seventeen. The skills and concepts presented in the training curriculum are broad enough to apply to a myriad of difficult populations.

Although no specific commitments are set, the practicum student would like to present workshops in de escalation through the student's local training outreach - the Illinois Council on Training (ICOT), or possibly through conferences sponsored by the Illinois Association of Child and Youth Care Workers (IACYCW). Based on the practicum project, this student plans to work on a paper for appropriate journal publication.

With the increased placement of aggressive youth in residential facilities, the need for an improved ability to de escalate situations will become even more imperative than it has in the past. This student would expect to see more research and programs, continuing to be explored, to address the problems of working with these youth.

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APPENDIX A

CALENDAR OF ACTIVITIES

Appendix A

Calendar of Activities

Schedule of Activities and Evaluation

Week One

1. The practicum student will meet with the co-trainers, to set up meeting and training dates, and go over training objectives. Alternate trainers will also be identified should any problems arise with the designated trainers.

Time required: 45 minutes

2. The practicum student will review Therapeutic Crisis Intervention (TCI), and Roland Oulette's 'Management of Aggressive Behavior' section on non-verbal, and verbal, communication skil[illegible]nd draw from these sources to develop a de escalation curriculum.

Time Required: 6 hours

3. The practicum student will schedule, and confirm, training dates with the focus unit supervisor and her staff. A training overview will

be presented to staff within their unit meeting.

Time required: 20 minutes

Week Two:

1. The practicum student will review the training curriculum with co-trainers, and note suggested revisions.

Time required: 1 hour

2. The practicum student will revise the training curriculum.

Time required: 2 hours

3. The practicum student will review the unit supervisor's present level of supervision, and individual staff feedback.

Time required: 45 minutes

4. The practicum student will review incident and discipline reports, and the running log.

Time Required: 1 hour and 30 minutes

5. The practicum student will note needed changes in documentation of incident reports, and the running log.

Time required: 45 minutes

Week Three:

1. The practicum student will meet with co-trainers to go over training curriculum revisions.

Time required: 30 minutes

2. The practicum student, along with co-trainers, will develop the 20 question written post-test.

Time required: 45 minutes

3. The practicum student will meet with the unit supervisor, and practice appropriate documentation of incident and discipline reports, and the running log.

Time required: 45 minutes

4. The practicum student will contact practicum advisor, and review progress, and potential problems.

Time required: 1 hour

Week Four:

1. The practicum student will develop a training outline.

Time required: 30 minutes

2. The practicum student, along with co-trainers, will develop role play situations, and checklist for evaluation of trainees' skill proficiency.

Time required: 2 hours

3. The practicum student will review staff observational feedback forms, with the unit supervisor.

Time required: 1 hour

Week Five:

1. The practicum student will meet with co-trainers, and set job responsibilities, plan for needed materials - VCR, Flip Chart, and room reservation.

Time required: 1 hour

2. The practicum student will do an abbreviated practice training to assess problem areas, and rectify same.

Time required: 1 hour and 30 minutes

3. The practicum student will review the unit supervisor's role and responsibilities with her.

Time required: 30 minutes

Week Six:

1. The practicum student, along with co-trainers, will conduct a 3 hour training on two days of this week.

Time required: 6 hours

2. Along with co-trainers, the practicum student will review the training, and note problem areas and any necessary revisions for future implementation.

Time required: 1 hour

3. The practicum student will reserve additional, and individual, training in the event any trainee did not pass either portion of the post-test (written or practical).

Time required: 2 hours

4. The practicum student, and co-trainers, will reassess role play proficiency of any trainee not passing after initial testing.

Time required: 1 hour

Week Seven:

1. The practicum student will review post-test results with the co-trainers, and unit supervisor.

Time required: 30 minutes

2. The practicum student will do three separate observations of focus unit to observe for transfer of skills.

Time required: 3 hours

3. The practicum student will review discipline and physical restraint reports, running log, and feedback sheets daily.

Time required: 2 hours and 30 minutes

Week Eight:

1. The practicum student will review discipline and physical restraint reports, and the running log, with child care staff during team meeting.

Time required: 1 hour

2. The practicum student will review discipline and physical restraint reports, the running log, and feedback sheets daily.

Time required: 2 hours and 30 minutes

3. The practicum student will meet with co-trainers, and review transfer of learning.

Time required: 45 minutes

Week Nine:

1. The practicum student will meet with focus unit team and record trainees feedback about training and transfer of training to a work situation.

Time required: 1 hour

2. The practicum student will observe the unit at 3 different times, which have been noted as problematic / transitional times, and write observational feedback regarding transfer of learning.

Time required: 3 hours

3. The practicum student will review discipline and physical intervention reports, and note the number of reports, length and intensity of specific behaviors.

Time required: 1 hour and 30 minutes

Week Ten:

1. The practicum student will meet with each trainee, individually, and illicit feedback on the transfer of training to work situations.

Time required: 2 hours and 30 minutes

2. The practicum student will review running logs, discipline and physical intervention reports, and feedback forms; and provide feedback to individual trainees and unit supervisor.

Time required: 2 hours

3. The practicum student will collect data to check if objective 5 has been completed.

Time required: 2 hours

All objective outcomes have been incorporated into the 10 week plan and, at the completion of the 10 weeks, outcome measures will be evident.

APPENDIX B
PHYSICAL INTERVENTION LISTING

Physical Intervention Listing
April 11, 1995

From: 01/01/95 To: 04/10/95 For: M , D

	Date	Primary Staff	Primary Intervention	Secondary Intervention
	01/16/95	Christopher, Colleen R	1-Person Containment(basket h	
Incident:	Daisy verbally provoked another resident and then attempted to fight her			
	01/25/95	Thompson, Nancy C	1-Person Containment(basket h	1-Person Containment(basket hold
Incident:	Daisy had a problem with following instructions and her verbal threatening the staff and peers.			
	01/25/95	Mueller, Alison L	1-Person Containment(basket h	
Incident:	Chasing after another resident threatening to hurt her.			
	01/26/95	Thompson, Nancy C	2-Person Escort Containment	2-Person Escort Containment
Incident:	Daisy returned to the dorm after therapy and she was loud and disrespectful and did not follow directives.			
	02/13/95	Holmes, Denise E	Belt Pivot	2-Person Escort Containment
Incident:	Daisy became very disruptive as well as destructive on the Dorm.There are no injuries to report.			
	02/26/95	Wagner, Dawn Marie	3-Person Escort Containment	
Incident:	To insure the safety of staff and the resident because resident threatened to throw lotions in staff's face.			
	02/27/95	Thompson, Nancy C	3-Person Escort Containment	None
Incident:	Daisy was directed to do her points and she decided she was going to take her plastic balls and throw them around the dorm.I directed her to take atime out and she began to temper dispay around the dorm.			
	02/28/95	Thompson, Nancy C	2-Person Escort Containment	2-Person Escort Containment
Incident:	Physical harm to staff			
	02/28/95	VanDeWalle, Holly A	2-Person Escort Containment	
Incident:	Resident theatening physical harm to staff			
	03/01/95	Thompson, Nancy C	2-Person Escort Containment	None
Incident:	Dasiy began to threaten a staff .			
	03/02/95	Garcia, Rosa J	2-Person Escort Containment	3-Person Escort Containment
Incident:	Daisy had become a danger to herself and others			
	03/02/95	Thompson, Nancy C	3-Person Escort Containment	None
Incident:	Daisy returned from AWOL and refused to follow instructions and became harmful to staff.			
	03/03/95	VanDeWalle, Holly A	3-Person Escort Containment	
Incident:	Resident causing physical harm to staff members			
	03/03/95	VanDeWalle, Holly A	3-Person Escort Containment	
Incident:	Physical harm to staff			
	03/07/95	Bauer, Victoria	2-Person Escort Containment	3-Person Escort Containment
Incident:	kicked staff			

Ulrich Children's Home

Physical Intervention Listing

April 11, 1995

From: 01/01/95 To: 04/10/95 For: M , D

	Date	Primary Staff	Primary Intervention	Secondary Intervention
	03/13/95	Thompson, Nancy C	3-Person Escort Containment	3-Person Escort Containment
Incident:	Daisy kicked, spit at, and bit staff members when they tried to calm her at school.			
	03/23/95	Parker, Jacquenette B	Belt Shirt Control(1-person esco	1-Person Containment(basket hold
Incident:	Daisy Morris attempted to push and bite staff . Daisy recieved no injuries. Staff (J.P.) recieved minor scratches on the left hand and wrist .			
	04/01/95	Holmes, Denise E	2-Person Escort Containment	None
Incident:	Daisy wasasked to give up a ball she was throwing against the wall and when staff Holmes went to take the ball Daisy took a swing at staff Holmes.			
	04/01/95	Thomas, Catherine A	1-Person Containment(basket h	None
Incident:	Client became upset because she could'nt go into the game at that moment.			
	04/05/95	Thompson, Nancy C	3-Person Escort Containment	2-Person Escort Containment
Incident:	Physical harm to peer and staff			
	04/07/95	Braun, Mara A	2-Person Escort Containment	
Incident:	Daisy threw breakable objects in her room, pushed staff, and attempted to hit staff.			
	04/08/95	Boyle, Sheryl A	1-Person Containment(basket h	2-Person Escort Containment
Incident:	Daisy tried to become assaultive towards a peer and for the physical safety of the peer staff(Sherry) placed Daisy in a basket hold. Another staff(Nancy) was called for assistance and she asked the peer to leave the room. At this point Daisy became assaultive and was placed in a two person containment to insure the safty of staff.			

Number Of Physical Interventions: 22

Uniek Children's Home

Physical Intervention Listing

April 11, 1995

From: 01/01/95 To: 04/10/95 For: G , S

	Date	Primary Staff	Primary Intervention	Secondary Intervention
	01/11/95	Christopher, Colleen R	1-Person Containment(basket h	
Incident:	Shantay punched me in the stomach			
	01/14/95	Christopher, Colleen R	1-Person Containment(basket h	
Incident:	Shantay was trying to fight another resident			
	01/16/95	Christopher, Colleen R	1-Person Containment(basket h	
Incident:	Shantay spit in her roommate's face and verbally provoked her			
	02/07/95	VanDeWalle, Holly A	1-Person Containment(basket h	1-Person Containment(basket hold
Incident:	Resident was threatening physical harm to peer			
	02/15/95	VanDeWalle, Holly A	1-Person Containment(basket h	2-Person Escort Containment
Incident:	Threatening peers and throwing objects			
	02/15/95	VanDeWalle, Holly A	1-Person Containment(basket h	1-Person Containment(basket hold
Incident:	Resident threatening/throwing objects at peers			
	02/15/95	VanDeWalle, Holly A	1-Person Containment(basket h	
Incident:	Resident threatening/throwing objects at peers and staff			
	02/22/95	Thompson, Nancy C	1-Person Containment(basket h	None
Incident:	Shantay began to run toward the cafeteria and when I went to stop her she began to kick at me and pull away.			
	02/22/95	Dorow, Tina K	1-Person Containment(basket h	1-Person Containment(basket hold
Incident:	Shantay returned to her dorm from therapy angry and punched a peer.			
	02/24/95	VanDeWalle, Holly A	1-Person Containment(basket h	
Incident:	RESIDENT ATTEMPTED TO BITE STAFF AND HIT PEER			
	02/25/95	VanDeWalle, Holly A	1-Person Containment(basket h	
Incident:	PHYSICAL HARM TO PEER			
	02/28/95	VanDeWalle, Holly A	1-Person Containment(basket h	2-Person Escort Containment
Incident:	Resident attempting to hit and kick peers			
	03/07/95	VanDeWalle, Holly A	1-Person Containment(basket h	
Incident:	Attempting to physically harm to peer			
	03/07/95	Thompson, Nancy C	1-Person Containment(basket h	None
Incident:	Shantayhad been trying to hurt staff by throwing her belongings out of her room and she had hit staff several times.			
	03/10/95	Braun, Mara A	2-Person Escort Containment	1-Person Containment(basket hold
Incident:	Resident was not following instructions when asked to go to room. She then pulled staff's hair and punched staff in the head. Resident was restrained to protect staff and other residents.			

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Ulrich Children's Home
Physical Intervention Listing
April 11, 1995

From: 01/01/95 To: 04/10/95 For: G S

	Date	Primary Staff	Primary Intervention	Secondary Intervention
	03/11/95	VanDeWalle, Holly A	1-Person Containment(basket h	
Incident:	Physical harm to staff			
	03/18/95	VanDeWalle, Holly A	2-Person Escort Containment	
Incident:	PHYSICAL HARM TO OTHERS			
	03/22/95	Dorow, Tina K	1-Person Containment(basket h	None
Incident:	Shantay was danger to herself and was trying to run away from me.			
	03/27/95	Boyle, Sheryl A	2-Person Escort Containment	
Incident:	DUE TO HER QUICKLY ESCALATING BEHAVIOR WHICH WAS STATRING TO IMPACT NEGATIVELY ON PEERS, SHANTAY WAS ESCORTED TO THE 3C DORM			
	03/27/95	Mueller, Alison L	1-Person Containment(basket h	Belt Shirt Control(1-person escort)
Incident:	Shantay provoked her roommate and her roommate wanted to retaliate.			
	04/05/95	Dorow, Tina K	2-Person Escort Containment	None
Incident:	Shantay was destroying property in family room and was a danger to herself and staff. Shantay was therefore placed in 2person escort containment and escorted to 3C by staff Dorow and Wilson.			
	04/08/95	Braun, Mara A	1-Person Containment(basket h	2-Person Escort Containment
Incident:	To ensure the safety of the residents Shantay was restrained after she punched another resident in the face.			
	04/08/95	Boyle, Sheryl A	Belt Shirt Control(1-person esco	1-Person Containment(basket hold
Incident:	Shantay started throwing objects at staff and to insure the safety of other she was escorted to the 3C unit to be removed from the other clients for their safety			
	04/09/95	Boyle, Sheryl A	1-Person Containment(basket h	None
Incident:	Shantay became physically out of control while being asked about an incident with another child. To insure the safety of the staff she was placed in a basketholdd			

Number Of Physical Interventions: 24

APPENDIX C
OCCUPATIONAL INJURY AND ILLNESS REPORT LOG

UHLICH CHILDREN'S HOME
Personnel Department
Occupational Injury/Illness Report Log
Reporting Month

This form is used in work injury cases where the employee had to leave the work premises to seek medical attention, or to go home, resulting in lost work hours or days.

Date of Injury	Employee's Name	Job Title	Description of Injury/Illness	Location of Injury	No. of Lost Work Hours/Day	Date Returned to Work	Disposition of Employee (Enter Code)
4-2-95	N T	Coordinator	punched in the nose by client	Jr. Girls Dorm	FT	4-2-95	FT.
4-5-95	T	Therapist	bite on leg	Family Room	FT	4-6-95	FT
4-7-95	Q M.	CHILD CARE WORKER	SCRATCHES Hand & WRIST	JR. GIRLS DORM	FT	4-7-95	F.T.
4/12/95	H	CC W	[illegible]	[illegible]	FT		

Code: PT - Resumed Part-Time Work
FT - Resumed Full-Time Work
MD - Resumed Modified Duty
RH - Rehabilitated to New Position
O - Other (Explain)

Submitted by:_____ Date:_____

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UHLICH CHILDREN'S HOME
Personnel Department
Occupational Injury/Illness Report Log
Reporting Month

This form is used in work injury cases where the employee had to leave the work premises to seek medical attention, or to go home, resulting in lost work hours or days.

Date of Injury	Employee's Name	Job Title	Description of Injury/Illness	Location of Injury	No. of Lost Work Hours/Day	Date Returned to Work	Disposition of Employee (Enter Code)
* 3/10/95	Bl. B.	Child care worker	bite	3D Juvenile Girls Dorm	1hr & 1/2	3/10/95	FT
3/16/95	K. W	CHILD AND YOUTH CARE WORKER	BITE LOOSE TEETH	JR. DORM	1½ HRS	3-17-95	FT

Code: PT - Resumed Part-Time Work
FT - Resumed Full-Time Work
MD - Resumed Modified Duty
RH - Rehabilitated to New Position
O - Other (Explain)

Submitted by: [redacted] Date:

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APPENDIX D
CURRICULUM (TEACHING GUIDE)

Appendix D

TEACHING GUIDE / CURRICULUM

DE ESCALATION OF AGGRESSIVE BEHAVIORS

KNOWLEDGE OF CHILDREN - <u>To become aware of the children for whom you have primary responsibilities.</u>

Teaching process - mini-lecture, written project & group discussion.

Lecture: All behaviors have meaning. Behaviors are means by which needs are met. It is important to know the children you work with to understand their needs and the way they go about meeting those needs.

Patterns of past behavior provides indication of how a child will respond to similar incidents in the future. A child's history of responding to stress, limits and authority will provide the information a child care worker needs to address and alter behaviors.

A child may be at very different levels of development - psychologically, physically, intellectually and emotionally. Understanding the child will enhance your ability to manage their behavior should a crisis arise.

Activity: Each child care worker will write answers to a series of questions regarding their primary. The group will then re convene to discuss their answers and how this can help them in working with the children.

1) What is your primary's favorite activity?

2) What motivates your primary to do well?

3) What consequence has the greatest impact on your primary?

4) What does your primary do to calm down after an upsetting incident?

5) What triggers anger in your primary?

VIOLENCE AND TRIGGERS OF PHYSICAL ASSAULT - <u>To identify some of the causes of violent behaviors and their correlation to age.</u>

Teaching process - mini-lecture.

Lecture: Violence is a function of age. Younger people are more likely to be violent than older people, and they can be expected to be violent more frequently. In the normal process of maturation, children progressively develop their ability to inhibit their impulsive and violently explosive behavior.

-Preschool children - typically have little ability to control their explosive outbursts. They are easily provoked into hitting, kicking, scratching and biting over relatively simple issues - related to such things as toys, candy and territory.

-Early elementary age children - have usually developed enough control to be able to avoid biting another child, or hitting them with a sharp

object during an explosive outburst. The issues that provoke assault at this age include such things as pride and friendship.

General causes of physical assault are fear, frustration, anger and manipulation. In residential settings, issues of fairness and denial of privileges are the most frequent causes of violent behavior.

Often staff may inadvertently contribute to violent episodes. Inexperienced staff perceive greater physical threat and use more physical intervention than may be necessary. Staff who are inflexible, overstructured and/or who are inconsistent in their behavior and awarding consequences may actually trigger aggressive behavior.

If you can identify what triggers a child, you will be able to anticipate situations and head them off before they have an opportunity to escalate. The earlier you can intercede in a crisis situation the more likely you can de escalate the situation.

ROLE PLAY: Sandra cannot find her new doll and she sees Tammy playing with a doll that looks like hers. ***"Hey that's my doll"***.

As a child care worker what would you do?

After the role play discuss what worked well and alternative interventions.

NON-VERBAL SIGNALS - <u>To become aware of non-verbal signals which may enhance staff ability to recognize a situation in early stages of escalation.</u>

Lecture: Non-verbal and verbal signals are the most widely used forms of communication. Often, direct care personnel are placed in danger of assault because they are unaware of verbal and non-verbal signals given by aggressors.

Up to **93%** of incidents which require force, could be avoided through physical presence and communication skills. **10%** of any message we deliver to people is verbal, and **90%** is non-verbal.

Consensus research notes - "In addressing any situation, if verbal and non-verbal communication conflicts, we should rely on the non-verbal

signals. **"Let me go, I'm ok"** , stated with clenched teeth and an angry tone tells us the person is still very angry.

In order of importance, the three key areas of non-verbal communication are:

1. **SPACE**
2. **EYE CONTACT**
3. **GESTURES AND POSTURE**

SPACE

Personal space is space that others are generally not expected to intrude upon. Personal space is important for us to maintain to be able to react to an assault. Likewise, if we enter others' personal space, we risk increasing their level of anxiety. Our personal space is about **3 ft.** in front of us, **1 & 1/2 ft.** to the side, and **5ft.** to the rear.

Activity

1. Pair people off and have them begin at about 5 ft. and move in closer to their partner until they feel a level of discomfort.

2. With your partner, position yourself about **2 ft.** away and try to touch their chin while they try to block you. Move back and repeat at **3 ft.** and **4 ft.**

Discussion Questions

-For the first exercise - at what point did you feel discomfort, and how did it make you feel?

-In the second exercise - at what distance did you have enough time to react to the actions of your partner?

Generally, if someone approaches closer than **3 ft.**, space is violated and they may react by moving away, tensing their muscles or even using physical force to gain some space.

It is important to note that we protect personal environments i.e. dorm rooms as much as we protect personal space. Entering a child's room may increase their level of anxiety.

A person has a reactionary gap of approximately **4 ft.**. Within the **4 ft.** zone, a person's actions will probably beat out our reaction.

Other factors to be aware of in regards to personal space: *males tend to need larger personal space than females, for younger children personal space does not exist, and people who have been abused may need greater personal space*. If you must enter someone's personal space, your hands should be at waist level or higher in a non-aggressive manner to reduce the time it takes to react to an attempted assault. When approaching an aggressor, it is best to stay within **4 to 6 ft.** away. If you stand beyond **6 ft.** you sent the signal that you are afraid of the person. While, if you stand within **4 ft.** we raise the anxiety level of the other person and reduce our ability to react to an assault.

When approaching, use a **45 degree** approach. This allows you to move in closer with less discomfort to the other person and provides protection to yourself. It is also best to approach on the weak side.

Eye Contact

-Using constant direct eye contact may be interpreted as trying to dominate the person and may raise their anxiety level, or it could be an attempt to challenge the other person. Staff on occasion may use this type of eye contact to take an assertive stance.

-If a person is looking around, they may feel cornered and be looking for a way to escape, or a weapon to use.

-Most people look at a target before they attack i.e. look at a shin before they kick... An attacker often will break eye contact immediately before an attack. This provides you with a cue to create more space and use verbal interventions.

-If a child's eyes are glistening or blinking - this is a sign of distress and the child is close to crying.

Gestures and Posture:

Be observant of a person's stance; whether they are open or closed. Also be cognizant of any changes such as color, breathing, muscles

tightening...

If the aggressor is sitting, you will be perceived as more aggressive if you stand. If you choose to stand, maintain greater space so as not to intimidate the child.

BEHAVIOR MANAGEMENT TECHNIQUES - <u>To become familiar with behavior management techniques from the least intrusive to the most directive.</u>

Teaching process: use of handout and ask participants to give examples of when each technique could be used.

STAGES OF CRISIS - To be able to identify the 4 phases of crisis.

teaching process: lecture, scenario presentation and discussion.

Phase 1 - the triggering event (what set things off).

Phase 2 - escalation (feelings begin to build and intensify).

Phase 3 - Crisis (the point where the child is out of control).

Phase 4 - Recovery (conflict resolution/teaching of alternative methods).

DE ESCALATION

1. Often by knowing a child well, and their pattern of behavior, we can anticipate a trigger and either remove it or prepare for it.

A. John gets excited in the car going on activities. He usually teases other children, poking and pulling hair.

In response: Staff have designated a seat in the front of the car, next to staff, to reduce excitement, over stimulation and increase direct supervision.

B. Ann returns from her visits in a terrible mood. She snaps at everyone as she walks in the door.

In response: Process with the child regarding her pattern of behavior after visits. Allow Ann to spend time in her room to reaclimate to the residential program. When she is ready, she may rejoin the group/routine on her own.

2. If we know things which are triggers for our residents we can pre-teach. Transition times are particularly hard for all residents.

- Sit children down and explain how things should run and what your expectations are **i.e.** *We are going down to dinner, everyone needs to stay in a line and when we arrive go to your assigned seats. Remember to keep the noise down during table conversations.*

3. Once you have identified a child's triggers, you have the opportunity to intervene before things can escalate.

A. Jan talks about Dana's mother - "Your mother's a drug addict, you will never go home".

Ideally residents could be separated and one staff talks to each girl. Later both are brought together to process.

B. Teaching a child to recognize their own triggers and identify ways for them to counteract the situation themselves.

i.e. *Walk away from a situation...*

i.e. *Go to staff and talk it out...*

FIVE INTERVENTION APPROACHES - To demonstrate an understanding of the five intervention techniques and how they can be used in practical situations.

teaching process - review handouts and discuss situations in which they could be used.

LIFE SPACE INTERVIEW - To demonstrate the use of a life space interview to address a typical crisis situation.

teaching process - lecture and role play.

*Use of the acronym **I ESCAPE** to remember the steps of the interview.*

Isolate the conversation / uninterrupted conversation focused on the problem situation.

Explore the child's point of view - what is their perception of the problem situation.

Connect their behavior to other past events - how is this behavior similar to behavior in past situations? Is their a pattern?

Alternative behaviors discussed - what other ways could you have reacted to the situation?

Plan Developed - Choose from one of the behavioral alternatives you have identified to use in the future.

Enter the child back into the routine. Re integrate the child into the activities in the milieu.

Scenarios

Demonstrate a life space interview using one of the following scenarios...

1. Danielle comes back from therapy and refuses to talk with anyone. Danielle then, begins to tear up her room including her roommates belongings. Sarah, her roommate gets up to go into the room.

2. Tammy hits Sandy and staff immediately consequent Tammy with a drop and loss of privileges. Tammy swears and states she does not care about points, or the level system. She continues to escalate behavior and throws pillows at Sandy.

APPENDIX E
ATTENDANCE FORM

UHLICH CHILDREN'S HOME
IN-SERVICE TRAINING RECORD

TOPIC: De-Escalation of Aggressive Behaviors

TRAINER: Aligon Mueller, Sherry Boyle, K. McCarthy Date: 8/9/95

Present: Time: 9:00 am 12:00 pm
From To

1. Rosa Julia Garcia 100
2. Adriana Alonso (75)
3. Dawn Wagner 100
4. Hollyann Bonilla 95
5. Jeremy Thompson 95
6. Jallayne Williams 95
7. Mala Braun 100
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
20.
21.

Return completed sign-in sheet to: Esther Lumague
after each session Campus Supervisor
Barbara Johnson

APPENDIX F
POST - TEST

Appendix F

POST TRAINING TEST

1. Kicking, hitting and scratching are typical behaviors for
   A. elementary age kids
   B. pre school kids
   C. Adolescents

2. Which is the most important area of non-verbal communication
   A. gestures
   B. eye contact
   C. space

3. What is the reactionary gap for a person to react to an aggressor
   A. 2 ft.
   B. 4 ft.
   C. 6 ft.

4. If an aggressive child looks at you then looks at your shin, most likely
   A. he is intimated by you
   B. he is embarrassed
   C. he is looking to hit or kick

5. The four stages of a crisis are
   A. trigger escalation, crisis , recovery
   B. de escalation power struggle, crisis, resolution
   C. confrontation, escalation, intervention, conclusion

6. The acronym used to help remember the steps of the Life Space Interview is

A. I ESCAPE
B. TRIGGER
C. RESOLVE

7. Which is not a behavior management technique

A. re directing
B. hurdle help
C. observing

8. Hypodermic Affection refers to

A. maintaining distance during interaction
B. show of additional caring or affection
C. withdrawal of approval

9. Trigger refers to

A. the event which sets things off
B. the punishment for poor behavior
C. the person involved in the incident

10. Which is the least intrusive management technique

A. hurdle help
B. planned ignoring
C. giving a time out

11. Which intervention technique emphasizes rules and routines

A. relating
B. teaching
C. accounting

12. Using a structuring intervention would work best for

A. a hyperactive child
B. a withdrawn child
C. a mature child

13. Why are patterns of behavior important

A. they are useful for training
B. they indicate how a child likely will act in a similar situation
C. they are useful for research

14. Which age is most likely to act out with physical aggression

A. the adult
B. a teenager
C. a preschooler

15. 90% of a message we communicate, comes from

A. our voice tone
B. non-verbal communication
C. verbal communication

16. Why might a child become aggressive if staff enters their room

A. personal environment is as important as personal space and they may feel violated
B. they think something might get stolen
C. they may need to clean their room

17. Crisis is

A. what set things off
B. the point where things are resolved
C. the point where a child is out of control and can no longer handle things

18. Which is not a step in the Life Space Interview

A. choosing alternative behaviors
B. giving consequences to a child
C. exploring the childs point of view

19. In residential settings, which is not one of the usual triggers of violent behavior

A. medical appointments
B. issues of fairness
C. denial of privileges

20. In approaching an aggressor, you should come from

A. behind
B. straight on
C. at a 45 degree angle

POST TEST ANSWER SHEET

1. B
2. C
3. B
4. C
5. A
6. A
7. C
8. B
9. A
10. B
11. C
12. A
13. B
14. C
15. B
16. A
17. C
18. B
19. A
20. C

APPENDIX G
CHECKLIST

Appendix G

CHECKLIST

NAME: _____ /

In the following list use **+** for demonstrated skills, and **0** if the skills were not used during the role play.

Proper use of voice tone and volume -

___/ raised voice only to focus attention on staff

___/ maintained even and consistent volume

___/ spoke more softly to model appropriate behavior and de escalate

COMMENTS:

Maintained appropriate proximity -

___/ approached at 45^ angle

___/ when threatened maintained a distance of 4 ft.

___/ unless the determination was made to physically intervene

COMMENTS:

Use of non-verbals to assist in de escalation -

___/ hand position

___/ eye contact

___/ posture

___/ sitting vs. standing

COMMENTS:

Use of one or more de escalation technique -

___/ re directing
___/ planned ignoring
___/ prompting

COMMENTS:

Follow Up -

___/ Life Space Intervention
___/ Conflict Resolution
___/ Re engaging child into milieu....

COMMENTS:

Avoids -

___/ screaming
___/ power struggle
___/ loud/overbearing tone
___/ bribery
___/ threatening

COMMENTS:

APPENDIX H
DOCUMENTATION REVIEW FORM

Documentation Review

Date of Review:_____ Staff Present at the Review:_____

_____

_____

Who was involved in the incident: staff_____resident_____

Date of incident:_____ Time:_____ Day of Week:_____

How long did the incident last:_____

Is there a pattern to this behavior:_____

What events preceded the incident: i.e. events which occurred earlier in the day which may have impacted the situation:_____

_____

_____

_____

_____

_____

What follow-up has occurred:_____

_____

_____

_____

_____

_____

_____

What could have been done differently in this situation:_____

_____

_____

_____

_____

_____

_____

_____

Recommendations:_____

_____

_____

_____

_____

_____

_____

Copies to:_____